Medicaid: Next Steps

Joe Flores, Senate Finance Committee

Friday, November 22, 2013

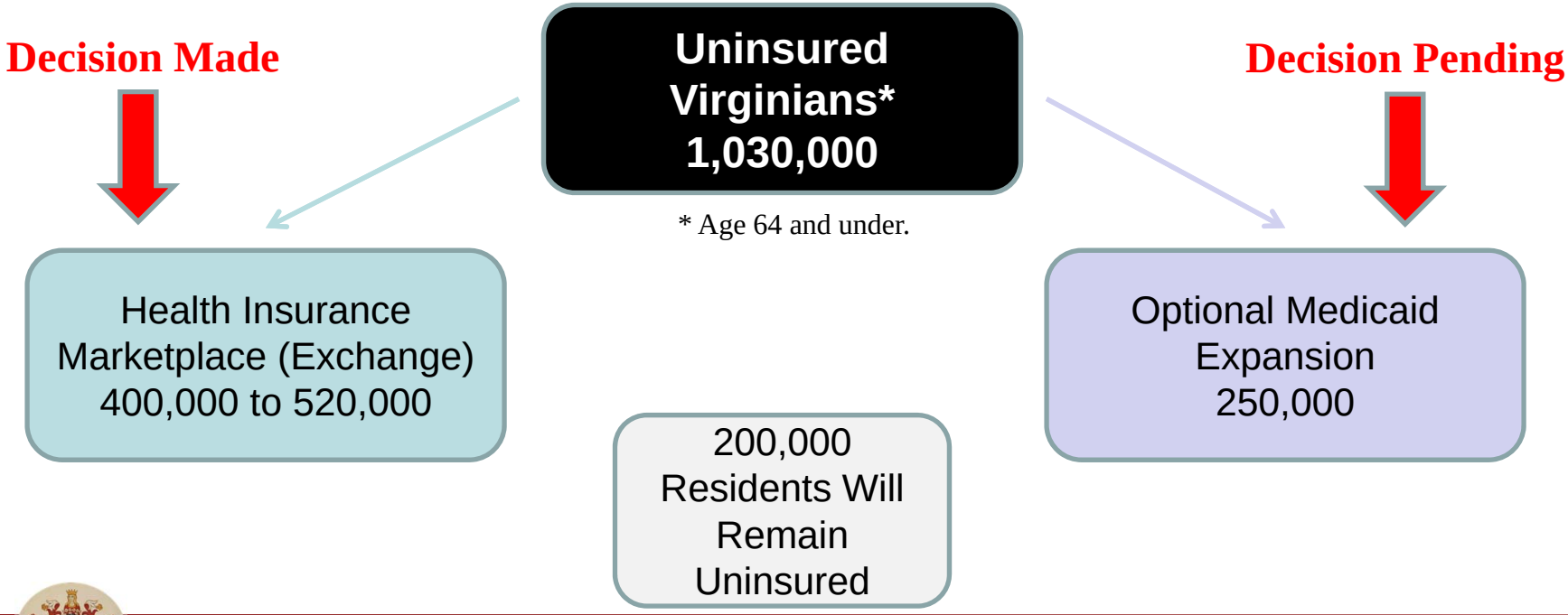
Overview of Presentation

- This presentation is designed to:
  - Remind policymakers why the issue of whether (or not) to expand health coverage to low-income Virginians is before the General Assembly;
  - Highlight some of the issues reviewed by the Medicaid Innovation and Reform Commission (MIRC) and provide some key facts about Virginia's Medicaid Program; and
  - Conclude by discussing next steps the Commonwealth may want to consider.

Why Are We Talking About Medicaid Again?

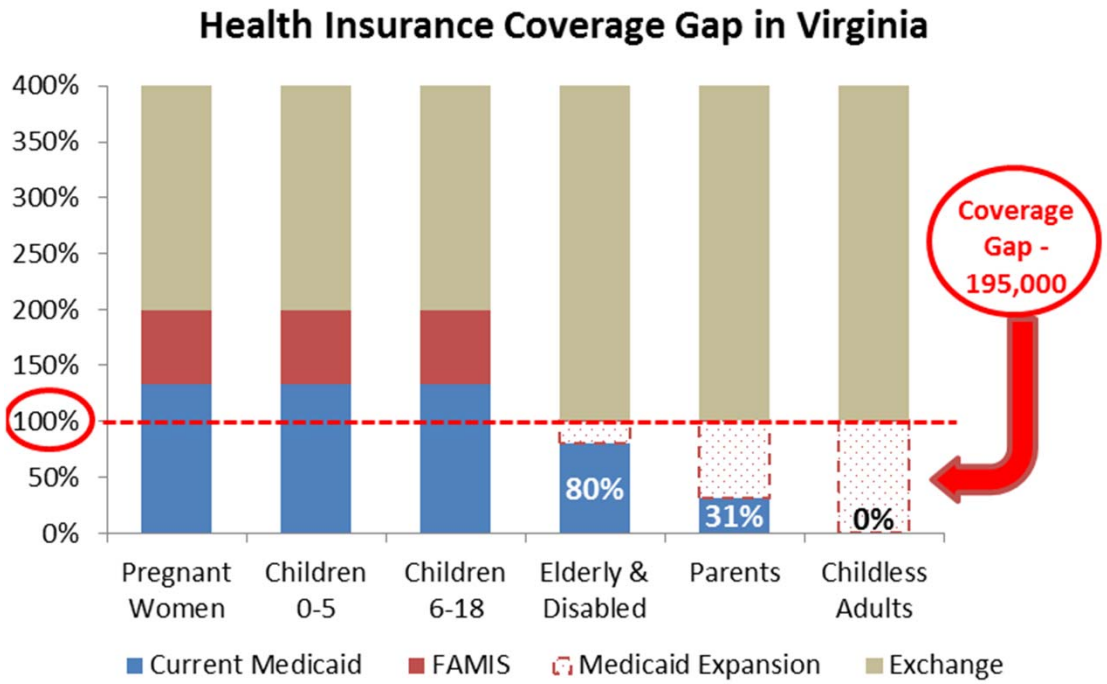
Opportunity to Access Health Care for the Uninsured…

- About half of Virginia's uninsured are expected to access health care through the federally-facilitated exchange (i.e., health insurance marketplace).
  - **Most of the remaining population of uninsured, about 250,000, are expected to enroll in Medicaid if coverage is expanded.**
  - Twenty percent of the uninsured are not eligible for Medicaid or the health insurance marketplace due to their citizenship status.

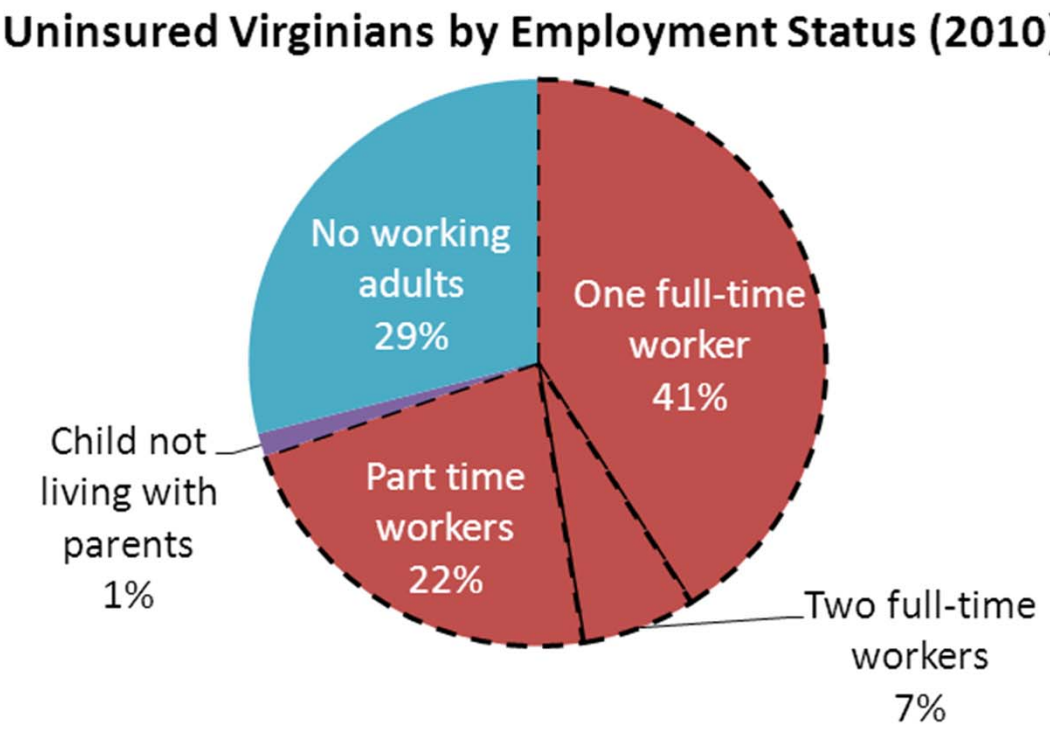


But a Coverage Gap Will Emerge on January 1, 2014…

- The Supreme Court's June 2012 decision created a "coverage gap" in states that do not expand Medicaid up to 138 percent of poverty.
  - 195,000 uninsured Virginians are expected to have too much income to qualify for Medicaid based on current income eligibility requirements but not enough income (i.e., 100 percent of poverty) to qualify for coverage through the exchange.



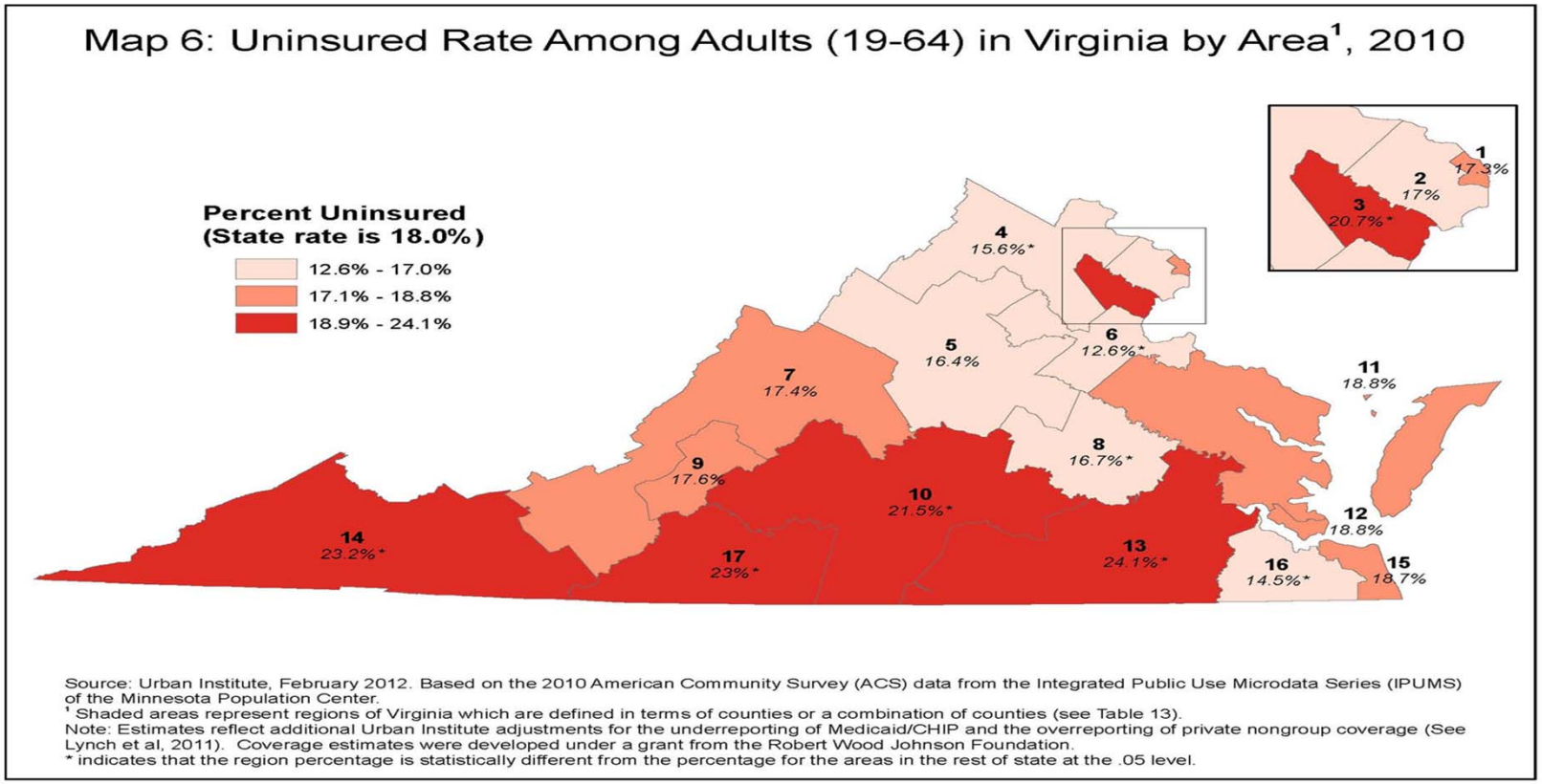
The Gap Includes Uninsured Virginians Who Are Working…



- **70 percent of the uninsured in Virginia live in families with at least one full-time or part-time worker.**
- Only 37 percent of small businesses (under 50 employees) offer health insurance in Virginia.

Who Reside In All Corners of the Commonwealth…

- A larger percentage of the population living in Southwest and Southside Virginia, as well as Prince William County, are uninsured.



Who Cannot Afford or Do Not Have Access to Health Insurance…

- **Health insurance is expensive** -- premiums for family coverage increased by 80 percent since 2003 -- from $9,068 to $16,351 per year.
  - The amount contributed by employees for family coverage has more than doubled since 2003.
- Many of the uninsured are **not offered health insurance** through their employer or **cannot afford to pay the premiums** if coverage is offered.
  - Employees in the agriculture and service sectors are less likely to have health insurance coverage.
- **Publicly-financed health care is targeted** to the elderly or disabled (i.e., Medicare) and pregnant women, children, the elderly and disabled, and low-income families (i.e., Medicaid).
  - Only parents with income up to 31 percent of poverty are eligible for Medicaid in Virginia ($7,146 for a family of four).
- Others are uninsured because they are undocumented or choose to go without coverage.

Whose Care is Often Uncoordinated or Delayed…

- The uninsured receive care that is fragmented, uncoordinated, and more costly as a result.

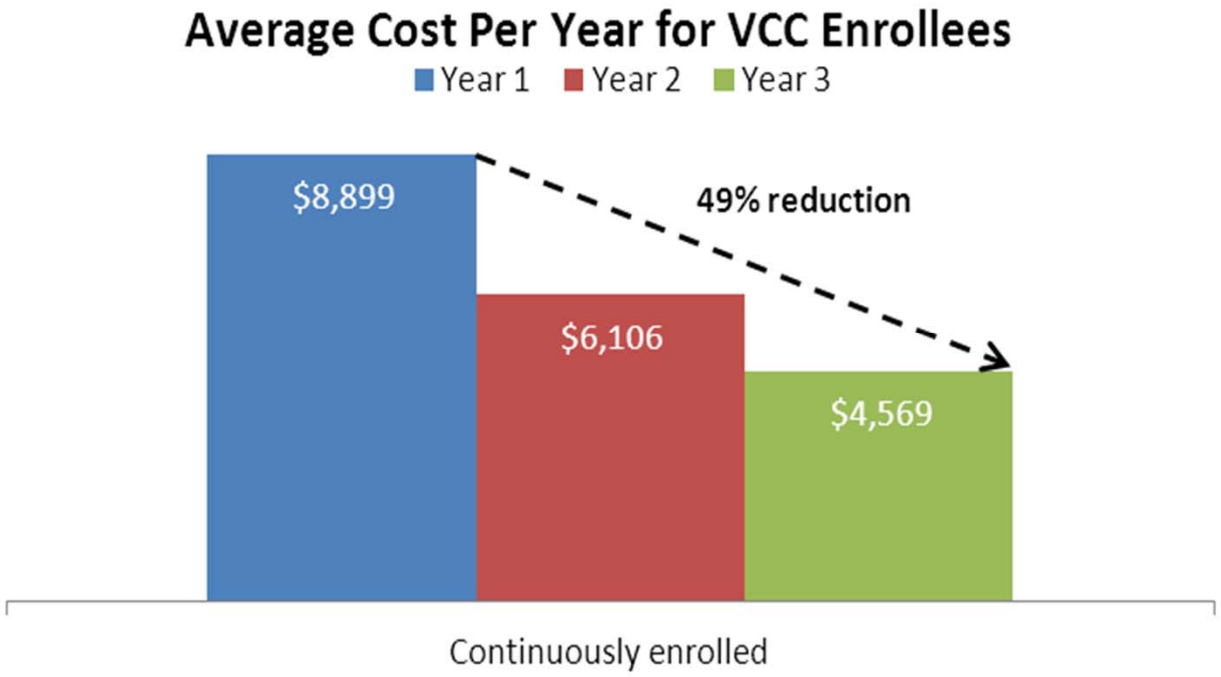
- Many of the uninsured are forced to use hospital emergency rooms after delaying care and treatment for routine illnesses or chronic diseases.

- We know that the uninsured:
  - Receive less preventive care;
  - Are diagnosed at more advanced disease states;
  - Receive less therapeutic care; and
  - Have higher mortality rates when a diagnosis is made.

- Many of the uninsured simply go without care.

But Who Could Benefit from Improved Access to Health Care…

- VCU's Coordinated Care Program, a community-based primary care model for the uninsured, has documented significant cost savings in the journal ***Health Affairs*** for the program's enrollees, primarily due to **fewer emergency room visits and inpatient stays**.



And Receive Care Through a Proven Delivery System…

- Most new recipients would enroll in a Medicaid managed care organization (MCO) at a fixed, monthly cost if coverage is expanded.

MCO financial incentive:
Accept financial risk for enrollees
Motivated to improve health of patients
Provide preventive care
Reward positive outcomes/not volume

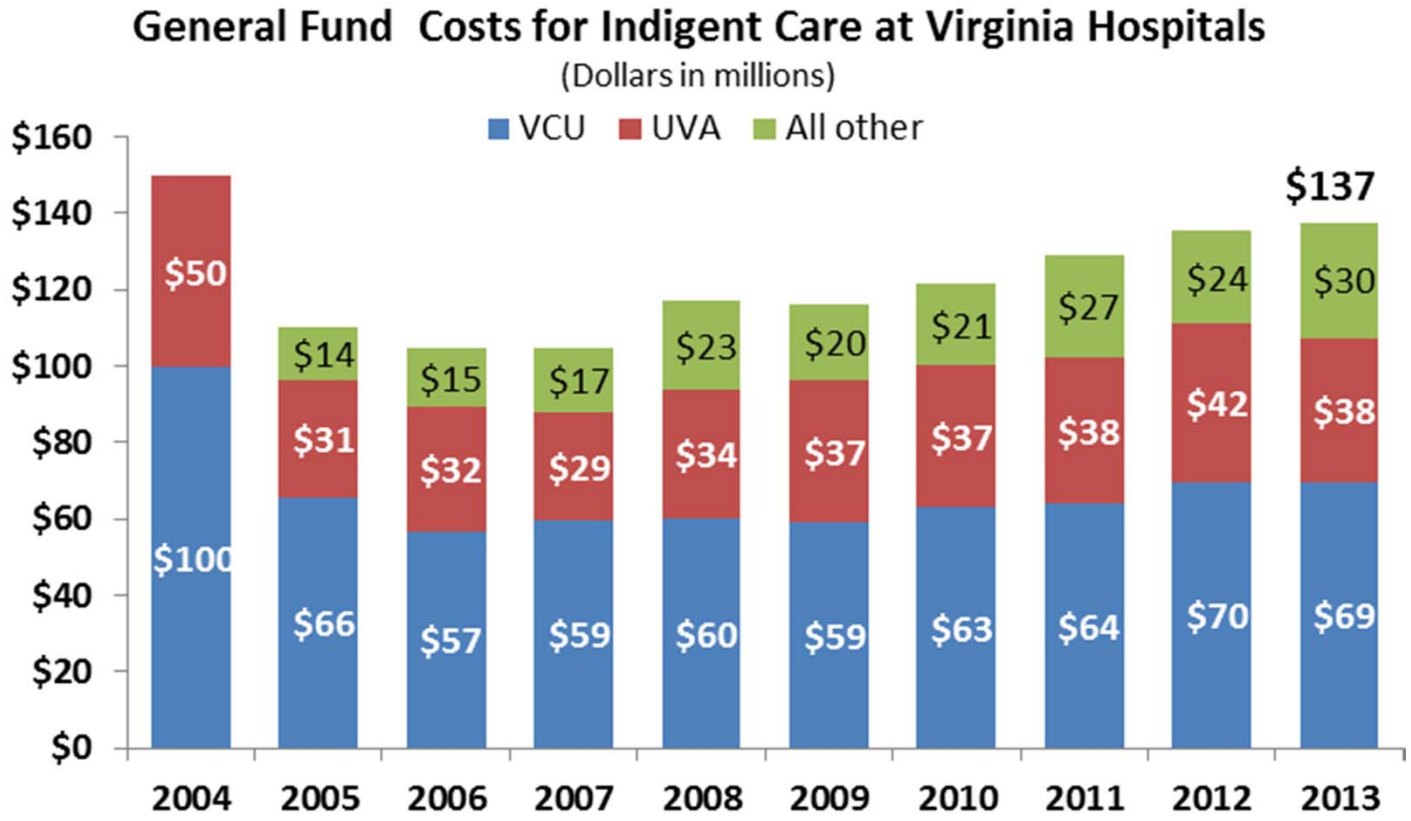
MCO programs:
Deliver comprehensive, coordinated care
Focus on appropriate use of care
Manage care of high-cost patients
Emphasize wellness

- By law, Medicaid MCOs must ensure that adequate provider networks are available to serve enrollees.

Medicaid MCOs have…
Managed most of the recession-driven enrollment growth that exceeded 210,000 since 2008, mirroring anticipated enrollment growth if coverage is expanded.
Have been adjusting their business model to ensure an adequate supply of providers are available to deliver care to eligible enrollees.
Have the flexibility to pay more than fee-for-service Medicaid to attract and retain quality providers.

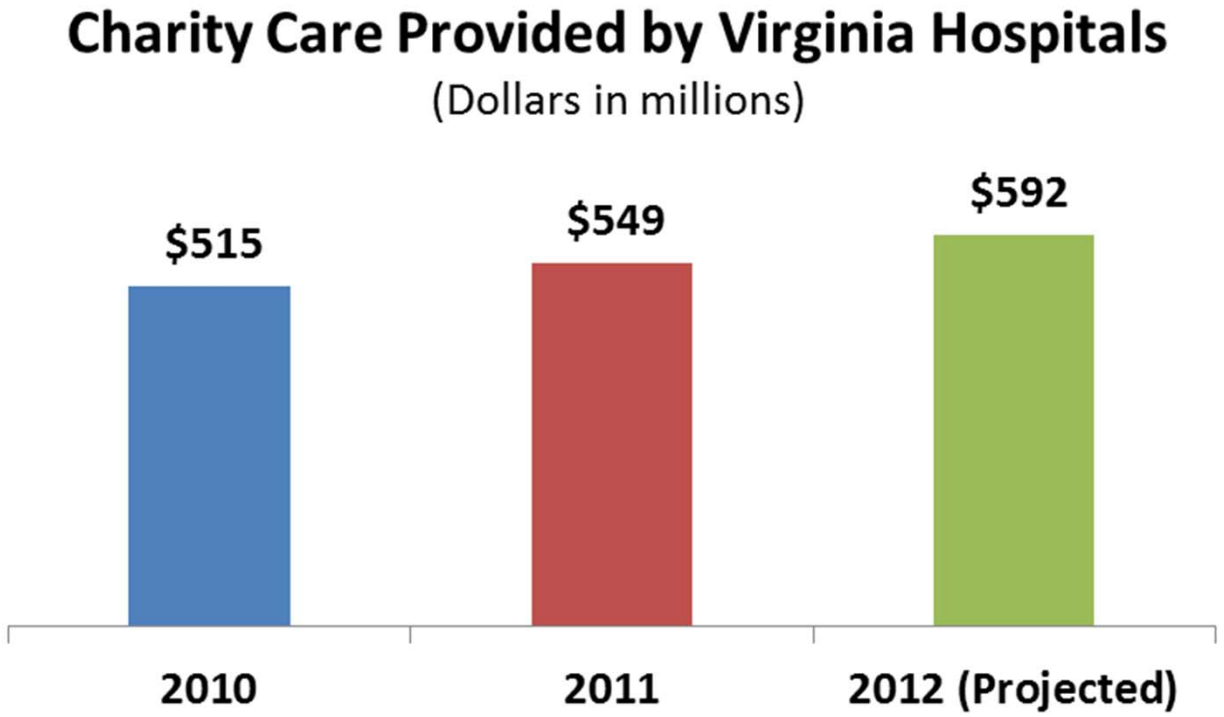
Rather Than at a Higher Cost in a More Inefficient Setting…

- Over the past ten years, Virginia spent, on average, **more than $123 million GF each year** subsidizing the cost of providing indigent care at VCU Health System, UVA Medical Center and private hospitals.



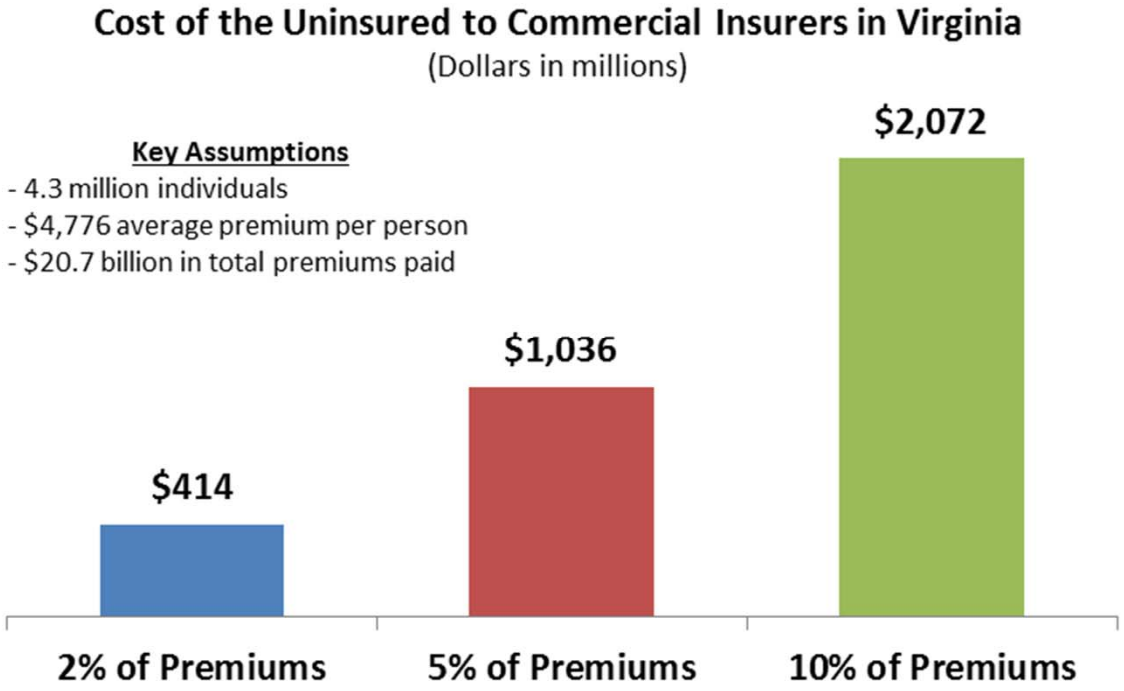
So That Costs Incurred by Hospitals Might be Reduced…

- Virginia hospitals provided over $500 million in uncompensated care during each of the past two years to low-income residents who were either uninsured or underinsured, a figure estimated to approach $600 million in 2012.



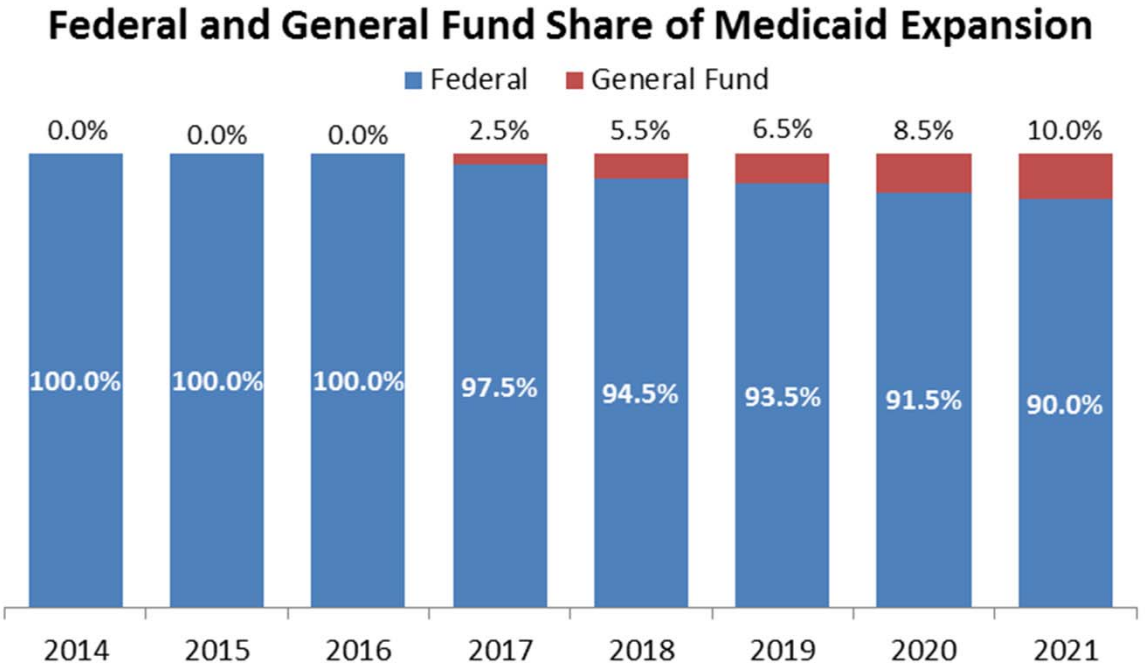
That are Otherwise Reflected in the Premiums That All Virginians Pay

- The cost of caring for the uninsured is reflected in the price paid by those who have health insurance.
  - This "hidden tax" is said to vary from as little as 1 to 2 percent of average monthly premiums to as much as 10 percent, depending on a state's health insurance market.

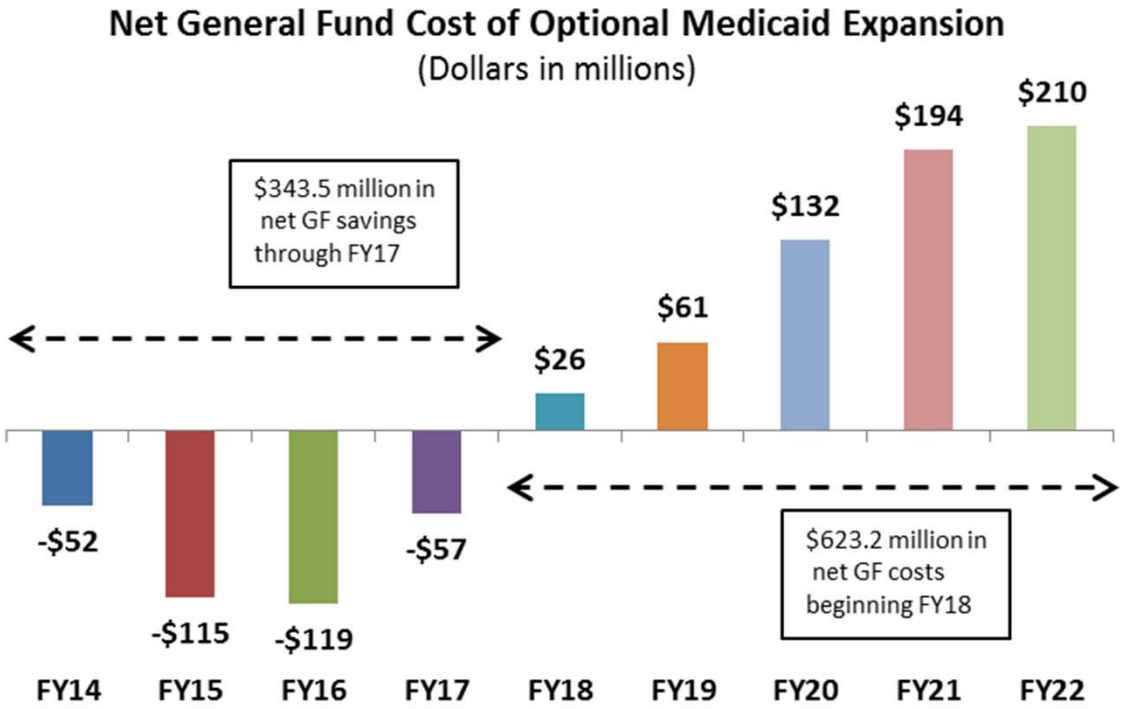


Coverage could be Extended at no General Fund Cost through CY 2016

- The general fund cost of expanding Medicaid will be zero in the first few years -- when pent-up demand for care may be highest -- with the federal government paying 100 percent of the cost through December 31, 2016.
  - It is no longer feasible to expand coverage before July 1, 2014; therefore, Virginia will forego <u>at least</u> $738 million in federal funding in CY 2014.



General Fund Savings are Estimated in The First Few Years



- DMAS is currently revising this estimate from December 2012 based on new information and various implementation dates.
  - This estimate does not reflect any GF savings from recent Medicaid reform efforts.

Review of Medicaid Innovation and Reform Commission (MIRC) and Key Facts About Medicaid

Different Approaches to Medicaid Reform and Expansion

- Budget conferees agreed that reforms should be put in place to coordinate care, monitor utilization and control costs before expanding Medicaid.
  - Major differences centered around **a)** how extensive the reforms would be, **b)** to which populations the reforms apply, and **c)** when expansion could occur.

- The **Senate**-approved language would have triggered the expansion of coverage upon federal approval of specific reforms related to services, benefits, and cost-sharing for the **expansion population**.

- The **House**-approved language required a more comprehensive list of reforms to the services, benefits, delivery systems, and administrative processes for **current enrollees** and the **expansion population** before expanding coverage.
  - Budget language required the 2014 General Assembly to decide whether or not to expand Medicaid effective July 1, 2014.

The Senate agreed to the House's comprehensive approach with the caveat that coverage would be expanded if the conditions for reform were met.

Activities of the Medicaid Innovation and Reform Commission (MIRC)

- The Commission has met four times since June 2013, gathering information from national experts, agency staff, and Secretary of Health and Human Resources Bill Hazel about:
  - Virginia's current Medicaid program including recent trends;
  - The assumptions behind the net general fund cost of expanding Medicaid;
  - Medicaid reform efforts being pursued in other states; and
  - The status of reforms in Virginia.

- The Commission also solicited input from the public through the MIRC website and a public hearing.
  - Over 2,600 individuals have submitted comments on the website.

- The MIRC has not voted on whether the conditions for reform set out in the Appropriations Act have been satisfied.

- Additional meetings are likely to be scheduled.

Medicaid is Not Just a Health Insurance Program for Low-income Virginians

Funded long-term care services not available through commercial payors
$2.5 billion in FY 2013

Nursing home residents – 27,862
ICF/MR residents - 1,470
PACE recipients – 1,090
HCBS waiver recipients – 38,000 (est.)

Provided care and assistance to low-income Medicare recipients
$441 million in FY 2013

Low-income Medicare beneficiaries - 170,000

Filled in service gaps and propped up Virginia's safety net
$1.2 billion in FY 2013

Behavioral health services – 59,633
Dental services for children – 332,335
Indigent care and other safety net providers – ($430 million in FY 2012)

Provided health care for low-income residents primarily children
$3.4 billion in FY 2013

Children - 620,000
Working parents - 120,000
Elderly and disabled - 240,000
Pregnant women - 51,000

Virginia's Medicaid Program Continues to Evolve

- As a condition of participating in Medicaid, states are required to cover certain populations and deliver specific services.

State Medicaid Programs Vary By Many Factors		
Income eligibility levels	Services provided	Benefit Limits
Provider payments	Cost-sharing	Delivery systems

- States shape Medicaid into their own program by seeking waivers from certain federal rules or regulations. For example, states may:
  - Provide home- and community-based waiver services as an alternative to placement in a nursing home or state facility;
  - Require mandatory participation in managed care; and
  - Experiment with reforms and innovations through demonstration waivers.

- Virginia has sought and received approval to implement all of these options to tailor the program to the Commonwealth's needs.

Who's Eligible for Medicaid in Virginia?

- To qualify for Medicaid, individuals must have limited income and belong to a mandatory "covered" group.

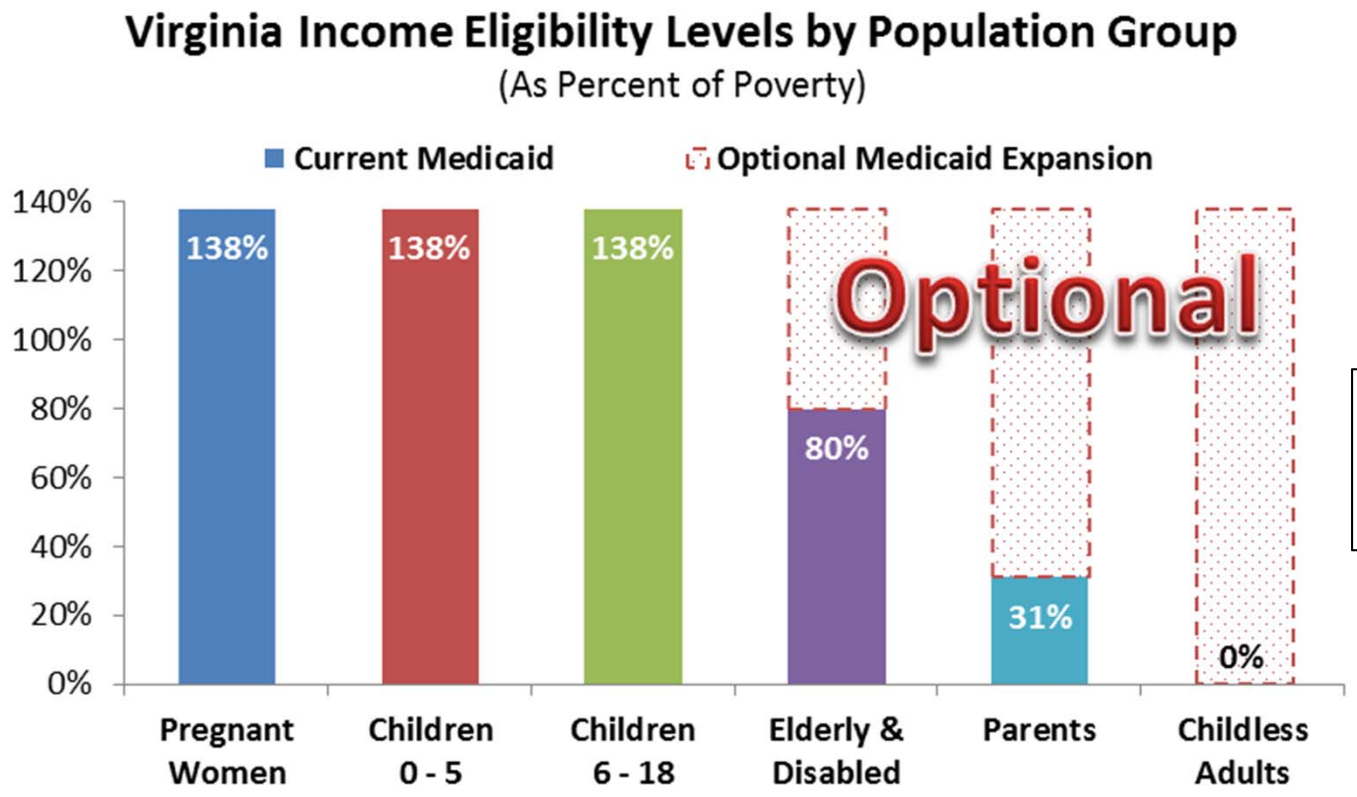
Mandatory Medicaid Population Groups	
Low-income Children	Low-income Parents with Children
Aged, blind and disabled	Pregnant women

- Prior to the Patient Protection and Affordable Care Act (ACA), states could increase access to Medicaid at each state's federal match rate by:
  - Increasing the income eligibility levels above federal minimum requirements; or
  - Expanding coverage to non-mandated population groups such as adults without children.

- Virginia has not chosen to expand coverage above the minimum federal level for most population groups.

Current Income Eligibility is Weighted Toward Vulnerable Populations

- While the Affordable Care Act required states to expand Medicaid up to 138 percent of poverty for all groups, the Supreme Court's decision in June 2012 made that requirement optional.

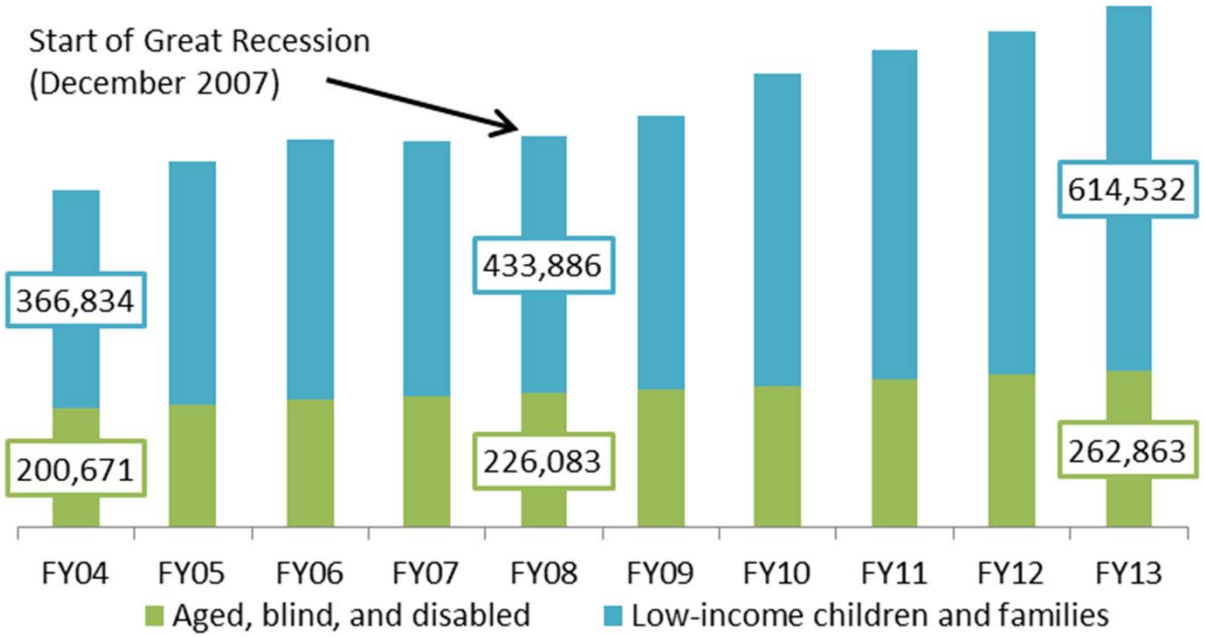


Federal poverty level is $23,550 for a family of four and $11,490 for an individual.

How Many Virginians are Covered?

- On any given month in FY 2013, 877,000 Virginians were enrolled in Medicaid.
  - 70 percent of Medicaid recipients were children or parents in low-income families and pregnant women.
  - This group tends to be more sensitive to changes in economic conditions.

Average Monthly Medicaid Enrollment by Population Group



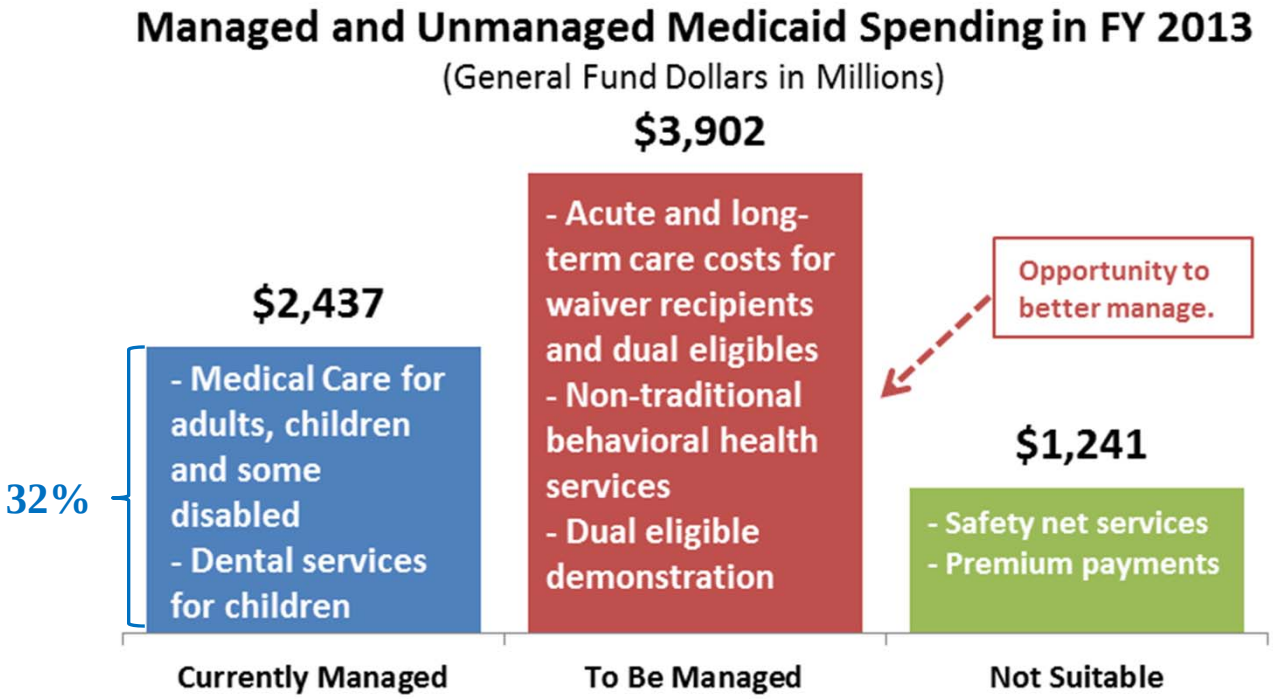
What Services does Medicaid Provide?

Mandatory	Optional
Inpatient hospitalization (#1)	*Home and community-based waiver services (#2)*
Nursing facility services (#3)	*Prescription drugs (#4)*
Physician Services (#5)	Eyeglasses, hearing aids & dental care (children)
Outpatient hospital services	Organ Transplants
Laboratory and X-Ray services	Psychologist and other behavioral health
Home health services	Podiatry
Early and Periodic Screening, Diagnostic and Treatment (EPSDT)	Intermediate care facilities for individuals with intellectual disabilities
Non-emergency transportation	Rehabilitative services
	Case management (certain waiver programs)
	Emergency hospital, hospice, prosthetic devices
	Physical, occupational and speech therapy

NOTE: Italics indicates one of five largest Medicaid expenditures according to JLARC (November 2013).

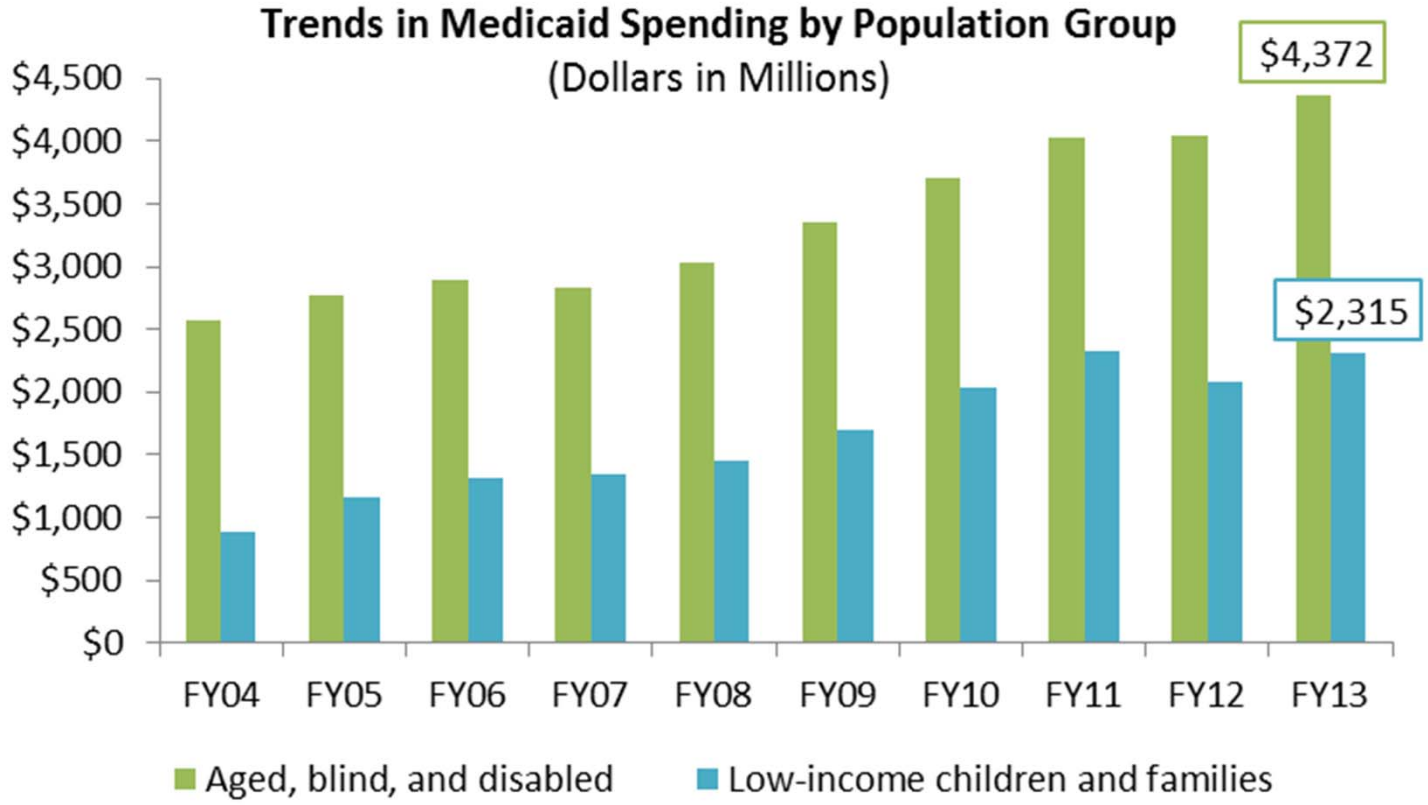
How are Medicaid Services Delivered?

- Most enrollees receive managed care from private health plans or providers, accounting for 32 percent of current Medicaid spending.
  - Reforms being pursued by DMAS will bring more than 80 percent of Medicaid spending under better coordination, and control, including populations receiving chronic and long-term care services.

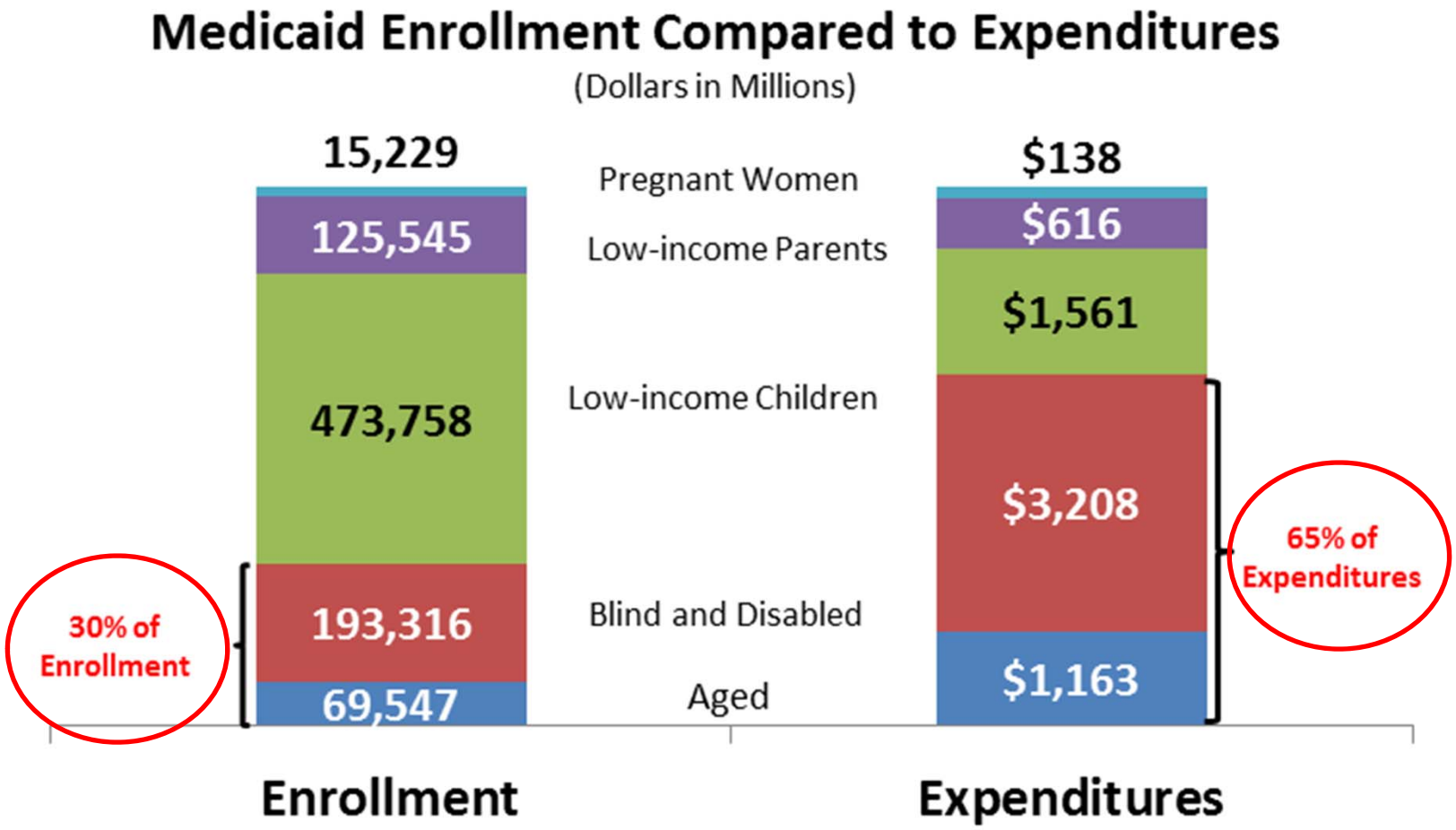


Medicaid Spending since FY 2004 (Revised)

- Rising enrollment, higher costs, and the utilization of home- and community-based waiver services as well as community mental health services are the primary drivers of spending during the past decade.



The Aged, Blind and Disabled Account for Most Medicaid Spending



Medicaid Reform Efforts since 2010

- In recent years, the Commonwealth implemented various reforms to better manage utilization, control costs and improve quality of care, yielding general fund savings but also avoiding future costs.

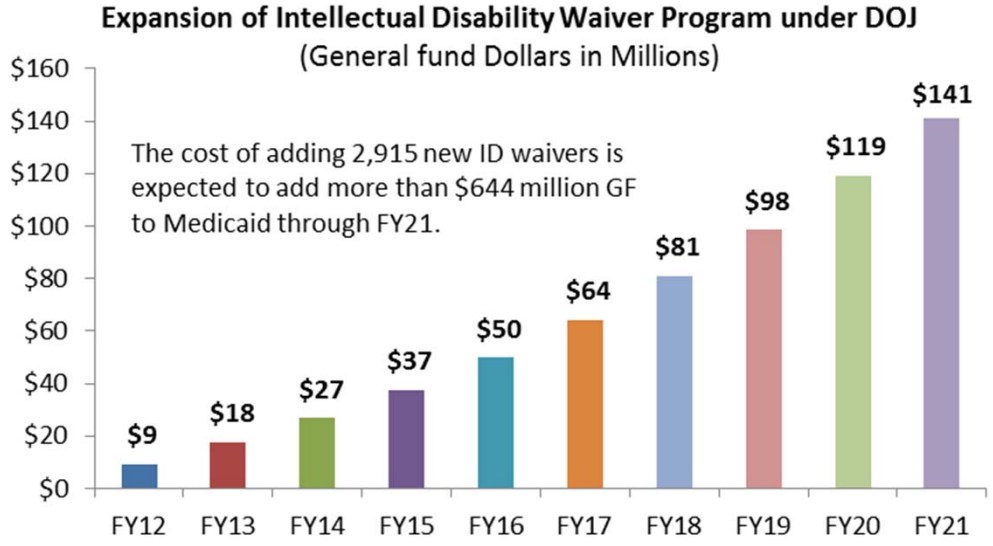
Recent Medicaid Reform Efforts
Description
Stepped-up enforcement by increasing staffing at Medicaid Fraud Control Unit and added audit positions within Office of Program Integrity to detect recipient fraud
Expanded managed care statewide and to behavioral health services and foster care children to coordinate care, oversee utilization and lower costs
Implemented Recovery Audit Contractor Program to identify improper provider payments
Imposed better oversight of children's mental health services by requiring additional prior authorization, provider audits and independent screening of applicants (i.e., VICAP)
Imposed competitive bidding for durable medical equipment

Virginia's Next Reform Challenge Revolves Around LTC Services

- The Commonwealth continues to move away from the outdated and inefficient fee-for-service payment model to a more responsible managed or coordinated care approach.

The biggest opportunity but the greatest challenge revolves around reforming the delivery of long-term care services, including home- and community-based waiver services.

- Virginia is adding 2,915 new ID waiver slots through 2021; better management of these critical services can leverage important resources for the Medicaid program.



Other States' Medicaid Reform Plans Mirror Virginia's Efforts

- Many of the themes that are emerging in state reform efforts were contemplated in budget language approved by the 2013 General Assembly.
  - Consider commercial-like services and benefits,
  - Require patient responsibility and engagement in wellness activities, and
  - Impose reasonable limitations on non-essential services.

State	Provide Premium Assistance	Require Co-Payments	Limit Benefits Provided	Encourage Healthy Behavior/ Incentives	Create Health Savings Accounts	Sunset Program
MI	X	X		X	X	X
OH		X				
IN		X	X	X	X	X
AR	X	X	X		X	X
IA	X	X	X	X		X
PA	X	X	X	X		

What are Arkansas and Iowa Considering?

- Arkansas' Private Insurance Option has been approved by the Centers for Medicare and Medicaid Services (CMS), while Iowa's "Health and Wellness Plan" is still pending.
  - CMS appears open to negotiation, but states are pushing the envelope on cost-sharing, benefit levels, and personal responsibility requirements.

	Arkansas	Iowa
Covered Group	Newly eligible up to 138% of federal poverty level (FPL)	Newly eligible between 100 – 138% of FPL (Medicaid for under 100%)
Premium assistance	Mandatory for newly eligible except medically frail	Mandatory for newly eligible except medically frail
Benefit levels	Alternative Benefit Plan (commercial-like insurance product)	Alternative Benefit Plan (equivalent to state employee benefits package)
Wraparound benefits	Paid for on FFS-basis by state	Not provided
Premiums	None	$20 per month. Waived if specific health changes are made
Cost-sharing (Limited to 5% of income annually)	Required for enrollees between 100-138% of FPL	$10 for non-emergency ER use beginning in 2nd Year

Status of Phase 1 Medicaid Reforms

- With the exception of the "Dual Eligible" Demonstration project, most of the Phase 1 reforms have been underway or progressing without delay.
  - Reforms are designed to better coordinate care, improve oversight, and reduce costs.

Phase 1 Reforms	
Description	**Status**
Implement Dual Eligible Demonstration Project	**Begins January 2014**
Enhance program integrity and fraud prevention activities	**Ongoing**
Transition foster care children into managed care	**To be Completed by June 2014**
Implement a new eligibility and enrollment system	**Began October 2013**
Improve access to veterans services	**Ongoing**
Provide better oversight and management of community behavioral health services	**Begins December 2013**

Status of Phase 2 Medicaid Reforms

- Many of the Phase 2 reforms are designed to make Medicaid more commercial-like, reward value and not volume, and encourage flexibility to promote innovation and improve the quality of care provided.

Phase 2 Reforms	
Description	**Status**
Develop commercial-like benefit package (e.g., service limits)	**Ongoing - Target date of July 2014**
Require patient responsibility, reasonable cost-sharing and patient engagement for current enrollees (e.g., chronic care management and assessment and wellness activities)	**July 2013**
Link payment to outcomes (e.g., quality withholds July 2014)	**July 2013**
Support medical homes and limited provider networks	**July 2013**
Parameters to Test Innovative Pilot Programs (e.g., Centers of Excellence to manage high-cost cases)	**Ongoing discussions**
Implement reasonable limitations on non-essential benefits	*
* Approval will need to be negotiated with CMS and is likely to be contingent upon a decision to expand coverage.	

Status of Phase 3 Medicaid Reforms

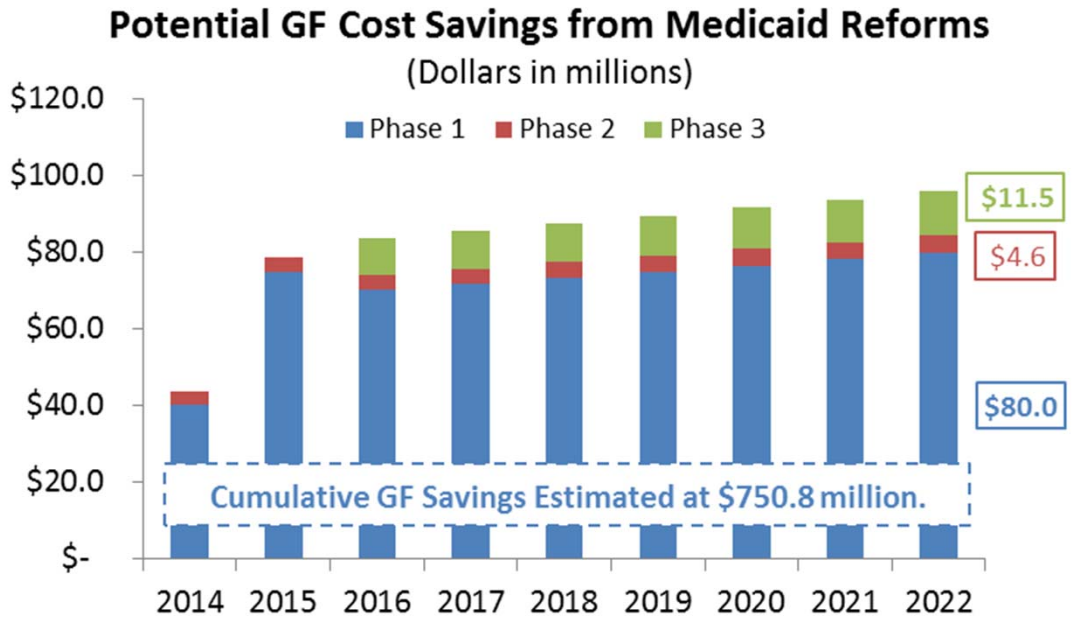
- Phase 3 requires DMAS to seek reforms to include remaining populations (i.e., long-term care and home- and community-based waiver services) into cost-effective managed and coordinated care.
  - Long-term care services are the most expensive and least coordinated care provided through Medicaid.

Phase 3 Reforms	
Description	**Status**
ID/DD Waiver Redesign	**Ongoing**
Enroll Home- and Community-based Waiver Recipients into Managed Care for Medical Needs	**October 2014**
All Inclusive Coordinated Care for long-term care beneficiaries	**July 2016**
Statewide Medicare-Medicaid (Duals) Coordinated Care	**July 2018**

What's Next?

Continue Implementing Medicaid Reform Initiatives

- The 2013 General Assembly set in motion a process to expand coverage if certain reforms were in place.
  - Many of the reforms are being implemented and are projected to reduce general fund spending by $96 million by FY 2022.



- The most challenging reforms involve LTC services that are not slated to be part of the benefit package offered to the expansion population.

Develop a Plan to Expand Coverage That is Unique to Virginia

- Many of the reforms included in budget language have been implemented or are proceeding with minimal delay.
  - Phase 2 reforms are closely linked to a decision to expand coverage.

- Virginia might consider the "Private Option Plan" presented by Secretary Hazel as the starting point for discussion. That plan included:
  - Using a broker to facilitate enrollment through the private health insurance market (e.g., Medicaid managed care organizations);
  - Paying a fixed payment to health plans for future enrollees;
  - Establishing "Centers of Excellence" for high-cost enrollees; and
  - Providing commercial-like insurance benefits at Medicaid payment rates and requiring patient-responsibility (i.e., cost-sharing and wellness).

- In addition to a trigger that would disenroll recipients if the federal government breaks its financial promise, what other conditions should the Commonwealth impose?
  - Additional "bells and whistles" will likely carry a price tag (i.e., administrative costs, negotiation delays).

Conclusion

- Policymakers have much to consider when deciding whether (or not) to expand coverage in Virginia.

- The 2013 General Assembly put Virginia on the path to expand access to health care provided certain reforms were made.

- It is clear that many, but not all, reforms have been implemented.
  - Should policymakers develop a private option to improve access to health care?
  - What provisions should be included to make it a uniquely Virginia plan?
  - How much will it cost? What is the cost of not expanding?
  - How long will it take to develop, negotiate, and implement such a plan?

- Regardless of what decision is made, attention needs to be devoted to the cost-effective delivery of health and long-term care services for recipients.
  - Virginia has not stood still as Medicaid spending has risen.
  - Many reforms have been in place for years.
  - Others are being successfully implemented right now.

Appendix I:
Phases of Medicaid Reform

Required Medicaid Reform Provisions	
Phase 1	Continue currently authorized reforms (i) Implementation of dual eligible project, (ii) enhanced program integrity and fraud prevention; (iii) inclusion of children enrolled in foster care in managed care; (iv) implementation of a new eligibility and enrollment systems; (v) improved access to Veterans services; and (vi) expedite the tightening of standards, services limits, provider qualifications, and licensure requirements for community behavioral health services.
Phase 2a	Implement value-based purchasing (i) Services and benefits provided are the types provided by commercial insurers and may include appropriate and reasonable limits on services such as occupational, physical, and speech therapy, and home care with the exception of non-traditional behavioral health and substance use disorder services; (ii) reasonable limitations on non-essential benefits are implemented; and (iii) patient responsibility is required including reasonable cost-sharing and active patient participation in health and wellness activities.
Phase 2b	Include Administrative Simplification to Permit Testing of Innovative Models (i) Leverage innovations and variations in regional delivery systems; (ii) Link payment and reimbursement to quality and cost containment outcomes; or (iii) Encourage innovations that improve service quality and yield cost savings to the Commonwealth.
Phase 3	Include all remaining Medicaid populations and services, including long-term care and home- and community-based waiver services into cost-effective, managed and coordinated delivery systems.

Appendix II:
Alternative Benefit Plan (ABP)

- ABPs must cover Essential Health Benefits as described in the Affordable Care Act plus additional Medicaid coverage requirements (e.g., rural health clinics, federally qualified health centers, non-emergency transportation).

Essential Health Benefits				
Ambulatory care	Emergency services	Hospitalization	Maternity & newborn care	Mental health and substance use disorders
Laboratory services	Prescription Drugs	Rehabilitative & habilitative	Pediatric care (i.e., oral and vision)	Preventive, wellness and chronic disease management

- States must select one of four benchmark options for the expansion population:
  - Standard BC/BC Option offered the Federal EHB program;
  - State employee coverage available to all state employees;
  - Commercial HMO with largest insured commercial, non-Medicaid enrollment; and
  - Secretary-approved coverage appropriate to needs of population.

Appendix III: State Reforms Efforts – Arkansas Private Option Plan

- Arkansas' plan received federal approval to operate its Demonstration Project through December 31, 2016.
- AR will provide premium assistance for non-frail adults with income up to 133 percent of poverty to purchase insurance through the state's insurance marketplace.
- Services that are not provided through the Alternative Benefit Plan will be paid for by the state's Medicaid program.
  - Non-emergency transportation;
  - Out-of-network family planning; and
  - Early and periodic screening and diagnostic treatment (EPSDT) for children under age 21.
- No cost-sharing for enrollees with income under the poverty level; cost sharing consistent with federal rules and cannot exceed 5 percent of family income.

Appendix III: State Reforms Efforts – Iowa Health and Wellness Plan

- Iowa's plan has not received federal approval.
- Up to 100 percent of poverty, adults will receive insurance equivalent to state employees health insurance.
  - No copayments except for non-emergency ER use.
  - No premiums for first year; premiums required if income > 50 percent of poverty and individual does not participate in preventive care or wellness activities.
  - Out of pocket costs are limited to no more than 5 percent of income.
- State will provide premium assistance for adults with income between 100 and 133 percent of poverty to purchase insurance through the state's insurance Marketplace.
  - Benefit levels, cost-sharing, and premium requirements are the same as those with income under 100 percent of poverty.

Appendix III: State Reforms Efforts – Michigan Plan

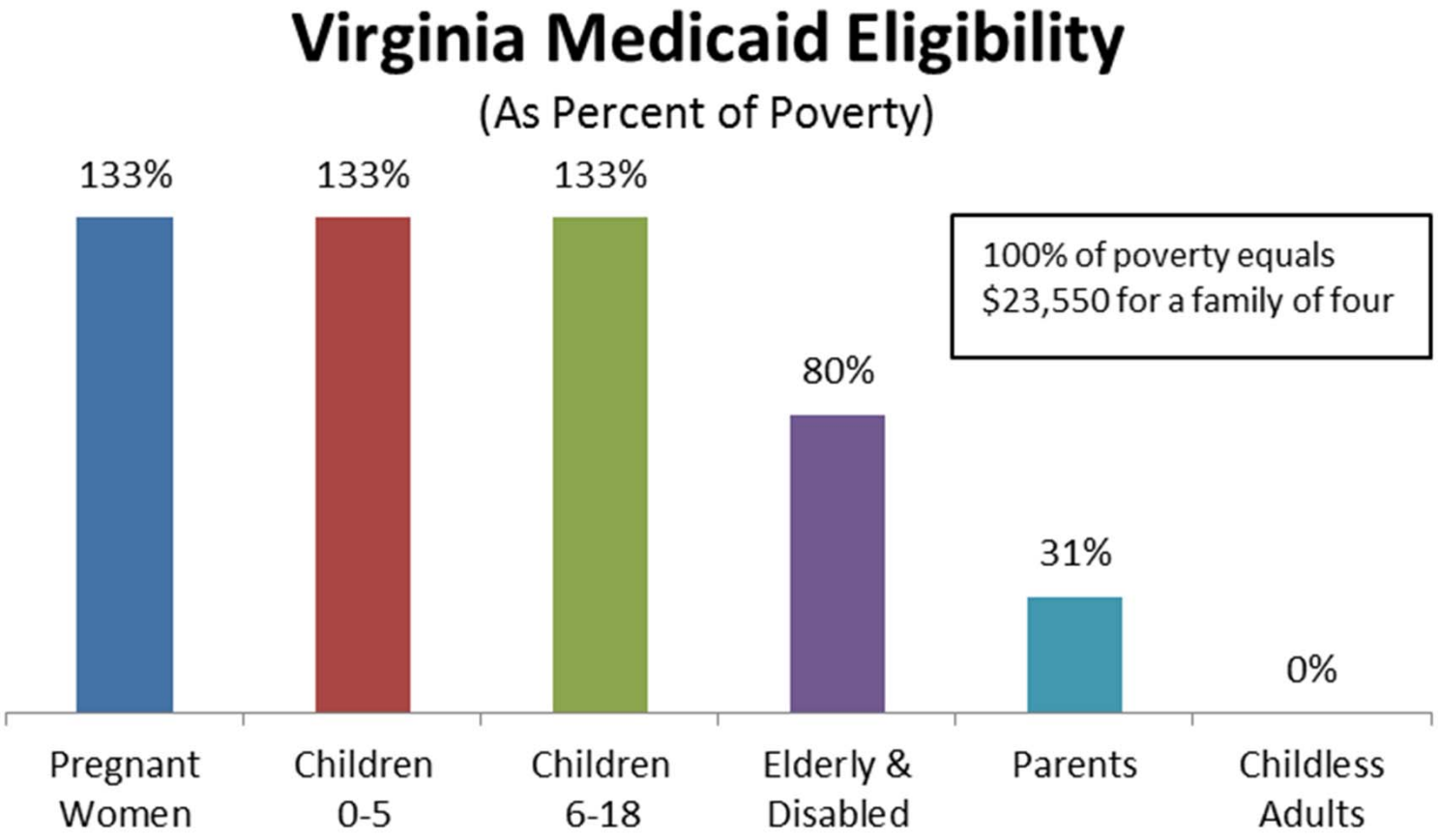
- Michigan's plan was only recently approved by the legislature.
  - Requires cost-sharing up to 5 percent of annual income for new enrollees with income between 100 and 133 of poverty; reduces cost sharing for enrollees who engage in healthy behaviors;
  - Enrolls adults in private health plans and not traditional fee-for-service Medicaid, with health savings accounts funded by enrollees or their employers to cover cost-sharing;
  - Requires that new Medicaid enrollees have access to primary care and preventive services and be offered the option of completing advance directives for end-of-life care;
  - Authorizes the Medicaid agency to identify innovations in Medicaid that improve the quality of care, reduce costs, or both; and
  - Allows the state to back out of the expansion if new state costs in 2017 and later years are not offset by other related savings in the state budget.

Source: New England Journal of Medicine, October 2013.

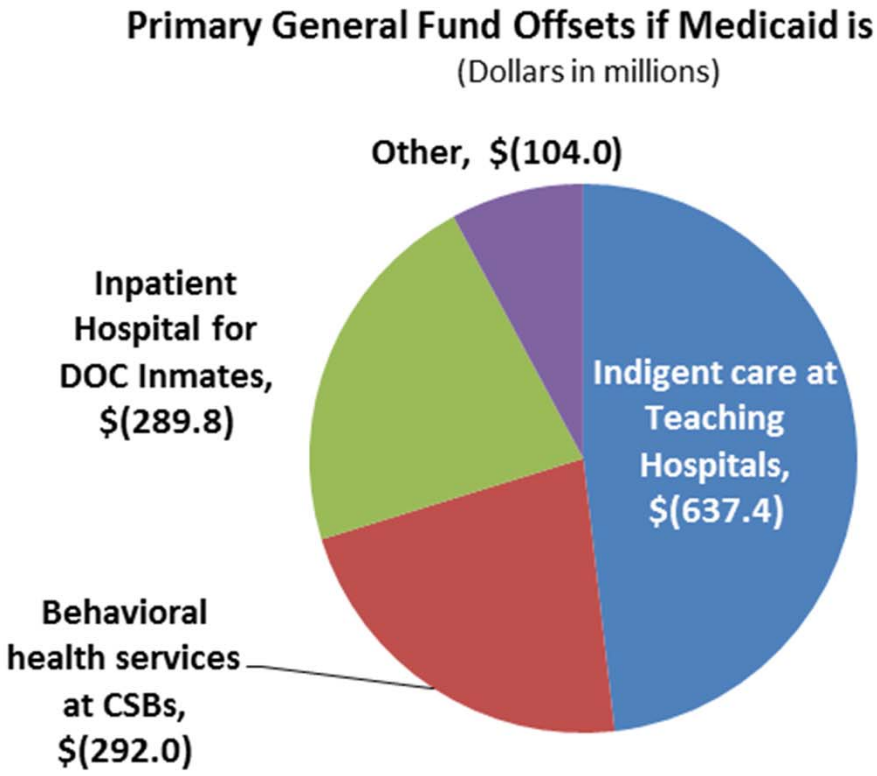
Appendix III: State Reforms Efforts – Healthy Pennsylvania

- Governor's Healthy Pennsylvania requires a redesign of existing Medicaid program that, if approved, would expand coverage through the federal exchange or "marketplace".
- Specific Medicaid proposal includes:
  - Aligning existing Medicaid with commercial-like benefit package (i.e., essential health benefits, mental health parity, and preventive care);
  - Promoting improved health outcomes and personal responsibility;
    - Eliminates copayments for prevention and physician visits.
    - Imposes a $10 copayment for inappropriate emergency room use.
    - Requires premiums up to $25 per individual or $35 per family but reduces them if recipients participate in health and wellness appointments and engage in job search and training programs.
- Upon federal approval of reforms to existing Medicaid program, PA would expand coverage through the exchange for eligible individuals with the exception of medically frail individuals.

Appendix IV:
Current Medicaid Eligibility Levels



Appendix V: Federal Dollars will Replace General Funds if Coverage is Expanded



Key Assumptions

Indigent care

50 percent reduction for indigent care at VCU and UVA.

Behavioral health services

Assumes that GF appropriated to CSBs for behavioral health services can be supplanted by enhanced federal Medicaid funding.

Inpatient hospital services

Assumes the cost of inpatient hospital services for DOC inmates can be transferred to Medicaid.

Appendix VI:
November 2013 Medicaid Forecast

- It is estimated that an additional $674 million in state funds will be needed to address caseload and cost growth in the Medicaid program.
- Medicaid spending is expected to rise by 6.6 and 3.2 percent in FY 2015 and FY 2016, respectively.
  - Payments made to Medicaid managed care organizations are expected to rise by 4 percent in FY 2015.
  - Annual enrollment growth continues to decline and is expected to average 2.5 percent in FY 2014.
- Behavioral health services continue to experience significant growth.